

**PART II of an application for insurance to the:** \_\_\_\_\_

(name of company)

**PROPOSED INSURED:**

Date of Birth: \_\_\_\_\_

Male  
 Female

\_\_\_\_\_  
Last Name First Name Middle Initial Month Day Year

1. a. Name and address of your personal physician.  
(If none, so state.) \_\_\_\_\_
- b. Date and reason last consulted. \_\_\_\_\_
- c. What treatment was given or medication prescribed? \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2. Have you ever been treated for or ever had any known indication of:  | Yes                      | No                       |
| a. Disorder of eyes, ears, nose or throat? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes; thyroid or other endocrine disorder? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorder of the blood? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco or any habit-forming drugs? _____  | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)

3. Are you now under observation or taking treatment?  Yes  No

4. Have you had any change in weight in the past year?  Yes  No

5. Other than above, have you within the past 5 years:
- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Had any mental or physical disorder not listed above? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury, or surgery? _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had an electrocardiogram, X-ray, or other diagnostic test? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?  Yes  No

7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?  Yes  No

8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?  Yes  No

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brother or Sister			

9. Females only: Yes No
- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

## PART III – PARAMEDICAL REPORT

NAME OF PERSON EXAMINED (PRINT)

DOB \_\_\_\_\_

---

First Name
Middle Initial
Last Name
Month
Day
Year

1. A. Have you smoked cigarettes in the past 10 years?  Yes  No
- B. Are you using tobacco in any other form?  
If yes, specify \_\_\_\_\_?  Yes  No
- C. Present cigarette smokers:  
(1) How many cigarettes do you smoke per day?  
(Number of cigarettes not number of packs) \_\_\_\_\_  
(2) How many years have you smoked? \_\_\_\_\_
- D. Past cigarettes smokers:  
(1) How many cigarettes did you smoke per day?  
(Number of cigarettes not number of packs) \_\_\_\_\_  
(2) How many years did you smoke? \_\_\_\_\_  
(3) When did you quit smoking? \_\_\_\_\_

2. A. Age at last birthday \_\_\_\_\_ years. B. Sex  Male  Female
- C. Does applicant appear stated age?  Yes  No If no, explain: \_\_\_\_\_
- D. Are there any obvious physical abnormalities?  Yes  No If yes, explain: \_\_\_\_\_

3. MEASUREMENTS (Estimated measurements are not acceptable.)
- A. Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in. B. Weight (clothed) \_\_\_\_\_ lbs
- C. For males only:  
I. Chest circumference: full inspiration \_\_\_\_\_ in. forced expiration \_\_\_\_\_ in.  
II. Abdomen at umbilicus \_\_\_\_\_ in.

4. BLOOD PRESSURE: Applicant to be sitting. Take pressure in both arms. If more than 10mm. difference, repeat in both arms; otherwise, repeat in either arm. If blood pressure is over 140/90, record additional readings, sitting after 15 minutes. Diastolic pressure to be noted at disappearance of sound (5<sup>th</sup> phase).

	Right Arm		Left Arm	
	Systolic	Diastolic	Systolic	Diastolic
1st Reading				
2nd Reading				
____ Min. Later				
____ Min. Later				

5. PULSE \_\_\_\_\_/min. (at rest) If over 90, repeat in 5-10 minutes and record \_\_\_\_\_/min.  
Any irregularities?  Yes  No If yes, enter number per minute \_\_\_\_\_

6. A. URINALYSIS: Albumin \_\_\_\_\_ Sugar \_\_\_\_\_ Other \_\_\_\_\_  
Is specimen being forwarded to Lab?  Yes  No Which Lab? \_\_\_\_\_
- B. Have any medications of any type been taken or administered in the past ten days?  Yes  No  
If Yes, specify \_\_\_\_\_
- C. If female, is applicant menstruating on day of examination?  Yes  No If Yes, please arrange to collect specimen on another day when all flow has stopped.

7. OTHER STUDIES (if required by instructions from Home Office)
- A. Electrocardiogram attached  D. Hemoglobin \_\_\_\_\_ gms. % or Hemotocrit \_\_\_\_\_ %
- B. Chest X-ray  E. Others (specify): \_\_\_\_\_
- C. Vital capacity \_\_\_\_\_ Liters 1 second \_\_\_\_\_ Liters

I certify that I personally asked each and every question on the Part B – and accurately recorded the answers thereon, I personally performed the physical measurements and observations recorded on this page.

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
(Signature of person completing form)

\_\_\_\_\_  
PARAMEDICAL FIRM NAME AND ADDRESS (PRINT OR STAMP)



Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont Aids Hotline for information about free testing, the number is listed below) and any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the informed consent form any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;
2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to retest once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that retest.
3. If you are denied insurance because of a positive test result, you may request a retest once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such retest is negative, an insurer may not deny coverage based upon the initial test results.

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV antibodies.



**Informed Consent**      *To be signed at the time when medical professional or company agent obtains sample.*

This statement has been read aloud to me and I understand this **HIV TESTING INFORMATION STATEMENT & CONSENT FORM**. I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

\_\_\_\_\_  
 Name of Proposed Insured

\_\_\_\_\_  
 Signature of Proposed Insured      Date

\_\_\_\_\_  
 Birth date

\_\_\_\_\_  
 State of Residence

\_\_\_\_\_  
 Name of Medical Professional or  
 Company Agent Collecting Sample

\_\_\_\_\_  
 Signature of Medical Professional or Company Agent

---

**Notification of Test Results**

*To be completed at time of application or when a Medical Professional or company agent obtains sample.*

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_